PROPOSED RULE MAKING
(RCW 34.05.320)

CR-102 (7/10/97)
Do NOT use for expedited adoption

Agency: Office of the Insurance Commissioner

X Original Notice
☐ Supplemental Notice to WSR _____
☐ Continuance of WSR

XPreproposal Statement of Inquiry was filed as WSR 98-13-088 ; or
☐ Expedited Adoption -- Proposed Rule Making notice was filed as WSR _____; or
☐ Proposal is exempt under RCW 34.05.310(4).

(a) Title of rule: (Describe Subject)
Chapter 284-66 WAC, Washington Medicare Supplement Insurance Regulation

Purpose: Update the regulation and bring it into compliance with recently enacted state and federal law

Other identifying information: Insurance Commissioner Matter No. R 98-14

(b) Statutory authority for adoption: RCW 48.02.060, 48.20.450, 48.20.470, 48.30.010, 48.44.050, 48.46.200, 48.66.041, 48.66.050, & 48.66.165

Statute being implemented: RCW 48.66.110, 48.66.130, 48.66.160, & 48.66.165

(c) Summary: The proposed rules endeavor to update the regulation and make technical changes to bring the chapter into accord with state and federal legislative changes.

Reasons supporting proposal: Amendments incorporating federal changes are required to keep the state in compliance with federal requirements. Amending the rule to incorporate the state legislative changes and making technical changes will eliminate conflicts between the RCWs and WACs and eliminate some confusion. This is a part of the Commissioner's Regulatory Improvement Process.

(d) Name of Agency Personnel Responsible for:		Office Location	Telephone
1. Drafting.....	Jon Hedegard	Olympia, WA	(360) 664-4629
2. Implementation....	Lee Barclay	Olympia, WA	(360) 586-3685
3. Enforcement.....	Carol Sureau	Lacey, WA	(360) 407-0048

(e) Name of proponent (person or organization): Deborah Senn, Insurance Commissioner — Private / Public / X Governmental

(f) Agency comments or recommendations, if any, as to statutory language, implementation, enforcement and fiscal matters: None

(g) Is rule necessary because of:			If yes, ATTACH COPY OF TEXT
Federal Law?	X Yes	☐ No	Citation: BBA - PL 105-
Federal Court Decision?	☐ Yes	X No	BBRA – PL 106-113
State Court Decision?	☐ Yes	X No	TWWIIA – PL 106-170

(h) HEARING LOCATION:
Senate Hearing Room 4
John Cherberg Building, 14th & Water
Olympia, WA

Date: December 27, 2000 Time: 1:00 p.m.

Assistance for persons with disabilities: Contact Lori Villaflores by December 26, 2000 TDD (360) 407-0409

Submit written comments to:
Kacy Brandeberry
P.O. Box 40255
Olympia, WA 98504-0255
E-Mail: Kacyb@oic.wa.gov
Fax: (360) 664-2782 By: December 26, 2000

DATE OF INTENDED ADOPTION: December 28, 2000

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON

FILED
NOV 22 2000

TIME 11:25 AM
WSR 00-23-128

NAME (TYPE OR PRINT)
William J. Hagens

SIGNATURE

TITLE
Deputy Insurance Commissioner, Health Policy

DATE
November 22, 2000

(j) Short explanation of rule, its purpose, and anticipated effects:

Technical changes are made to bring the code in alignment with federal and state legislation that has occurred since the last update of the chapter. Amendments incorporating federal changes are required to keep the state in compliance with federal requirements. Amending the rule to incorporate the state legislative changes and making technical changes will eliminate conflicts between the RCWs and WACs and eliminate some confusion. This is a part of the Commissioner's Regulatory Improvement Process.

Does proposal change existing rules? X YES ☐ NO If yes, describe changes:

284-66-030 – a federal definition of "Medicare+Choice Plan" is added
284-66-063 – a new (1)(e)(iii) is added. (2)(e) is amended as is (3)(h) to comply with federal law
284-66-066 – is amended to include high deductible "F" and "J" plans
284-66-077 – is amended to include federal language to allow for the possibility of certain enrollment options that may not be provided for under state law.
284-66-092 – is amended to correspond to the addition of high deductible "F" and "J" plans.
284-66-110 – technical changes corresponding to the update of the NAIC model regulation
284-66-120 - technical change corresponding to the update of the NAIC model regulation
284-66-142 – technical change to update for changed state law
284-66-170 – technical change to update for changed state law

(k) Has a small business economic impact statement been prepared under chapter 19.85 RCW?

X Yes. Attach copy of small business economic impact statement.
A copy of the statement may be obtained by writing to:

Kacy Brandeberry
P.O. Box 40255
Olympia, WA 98504-0255
E-Mail: Kacyb@oic.wa.gov

telephoning: (360) 664-3784
faxing: (360) 664-2782

☐ No. Explain why no statement was prepared

(l) Does RCW 34.05.328 apply to this rule adoption? X Yes ☐ No

Please explain: While the amendments are required to conform to federal and state law, the Commissioner is treating this as a significant legislative rule.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-030 Definitions. For purposes of this chapter:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and

(b) In the case of a group Medicare supplement insurance policy, the proposed certificateholder.

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy regardless of the situs of the group master policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates.

(5) "Direct response issuer" means an issuer who, as to a particular transaction, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

(6) "Disability insurance" is insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance appertaining thereto. For purposes of this chapter, disability insurance shall include policies or contracts offered by any issuer.

(7) "Health care expense costs" means expenses of a health maintenance organization or health care service contractor associated with the delivery of health care services which expenses are analogous to incurred losses of insurers. Such expenses shall not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, and "claims" processing costs.

(8) "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(a) Coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(b) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(c) Medicare+Choice private fee-for-service plans.

(9) "Policy" includes agreements or contracts issued by any issuer.

((~~(9)~~)) (10) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

((~~(10)~~)) (11) "Premium" means all sums charged, received, or deposited as consideration for a Medicare supplement insurance policy or the continuance thereof. An assessment or a membership, contract, survey, inspection, service, or other similar fee or charge made by the issuer in consideration for such policy is deemed part of the premium. "Earned premium" shall mean the "premium" applicable to an accounting period whether received before, during or after such period.

((~~(11)~~)) (12) "Replacement" means any transaction in which new Medicare supplement coverage is to be purchased, and it is known or should be known to the proposing agent or other representative of the issuer, or to the proposing issuer if there is no agent, that by reason of such transaction, existing Medicare supplement coverage has been or is to be lapsed, surrendered or otherwise terminated.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered on or after July 1, 1992. Only Medicare supplement policies or certificates meeting the requirements of this chapter may be delivered or issued for delivery in this state on or after July 1, 1992. After that date, no policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(c) Each Medicare supplement policy shall be guaranteed renewable and:

(i) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the Medicare supplement policy is terminated by the group policy holder and is not replaced as provided under (c)(v) of this subsection, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for such benefits as otherwise meets the requirements of this subsection.

(iv) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificateholder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(d) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(e)(i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within

ninety days after the date the individual becomes entitled to such assistance.

(ii) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(iii) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iv) Reinstitution of such coverages;

(A) Shall not provide for any waiting period with respect to treatment of preexisting
conditions;

(B) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(C) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for basic ("core") benefits common to all benefit plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packaged red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in case of hospital outpatient department services under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(3) Standards for additional benefits. The following additional benefits shall be included in Medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the Medicare Part B excess charges: Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (i)(ii) of this subsection and patient education to address preventive health care measures.

(ii) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) ((~~Feccal occult blood test and/or~~)) Digital rectal examination;

(B) ((~~Mammogram;~~

~~(C)~~)) Dipstick urinalysis for hematuria, bacteriuria, and proteinauria;

((~~(D)~~)) (C) Pure tone (air only) hearing screening test, administered or ordered by a physician;

((~~(E)~~)) (D) Serum cholesterol screening (every five years);

((~~(F)~~)) (E) Thyroid function test;

((~~(G)~~)) (F) Diabetes screening.

(iii) ((~~Influenza vaccine administered at any appropriate time during the year and~~)) Tetanus and Diphtheria booster (every ten years).

(iv) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current*

Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions shall apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services which assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by Medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

(k) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

AMENDATORY SECTION (Amending Order R 92-7, filed 8/19/92, effective 9/19/92)

WAC 284-66-066 Standard Medicare supplement benefit plans. (1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in WAC 284-66-063 (3)(k) and in WAC 284-66-073.

(3) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit shall be structured in accordance with the format provided in WAC 284-66-063(2) and 284-66-063(3) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the basic ("core") benefits common to all benefit plans, as defined at WAC 284-66-063(2).

(b) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible as defined at WAC 284-66-063 (3)(a).

(c) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined at WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized Medicare supplement plan "D" shall include only the following: The core benefit, as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined at WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined at WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e), and (h) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific

benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

((~~(h)~~)) (i) Standardized Medicare supplement benefit plan "H" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined at WAC 284-66-063 (3)(a), (b), (f), and (h), respectively.

((~~(i)~~)) (j) Standardized Medicare supplement benefit plan "I" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively.

((~~(j)~~)) (k) Standardized Medicare supplement benefit plan "J" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively.

(l) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-077 Open enrollment. (1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is sixty-five years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(2) Except as provided in WAC 284-66-170, subsection (1) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first three months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the three months before the coverage became effective.

(3) The issuance of a Medicare supplement policy or certificate shall provide the broadest opportunity for enrollment. Access shall be offered to applicants through subsections (1) and (4) of this section.

(4)(a)(i) Eligible persons are those individuals described in subsection (b) who, subject to subsection (b)(ii)(B), apply to enroll under the policy not later than sixty-three days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(ii) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) Eligible persons - An eligible person is an individual described in any of the following paragraphs:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(ii)(A) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

(I) The certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(II) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;

(III) The individual is no longer eligible to elect the plan because of

a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(IV) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(1) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(2) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(V) The individual meets such other exceptional conditions as the secretary may provide.

(B)(I) An individual described in subparagraph (4)(b)(ii)(A) of this section may elect to apply subsection (4)(a) of this section by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

(II) In the case of an individual making the election in subparagraph (B)(I) above, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subsection (4)(a) of this section shall only become effective upon termination of coverage under the Medicare+Choice plan involved.

(iii)(A) The individual is enrolled with:

(I) An eligible organization under a contract under Section 1876 (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(III) An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(IV) An organization under a Medicare Select policy; and

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (4)(b)(ii) of this section.

(iv) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A)(I) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

(B) The issuer of the policy substantially violated a material provision of the policy; or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(v)(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under

demonstration project authority, any PACE program under Section 1894 of the Social Security Act, an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

(B) The subsequent enrollment under (v)(A) of this subsection is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

(vi) The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five, enrolls in a Medicare+Choice plan under Part C of Medicare, or in a PACE program under Section 1894, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

(c) Products to which eligible persons are entitled.

The Medicare supplement policy to which eligible persons are entitled under:

(i) Subsection (4)(b)(i), (ii), (iii) and (iv) of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

(ii) Subsection (4)(b)(iv) of this section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection (4)(c)(i) of this section.

(iii) Subsection (4)(b)(vi) of this section shall include any Medicare supplement policy offered by any issuer.

(d) Notification provisions.

(i) At the time of an event described in subsection (b) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this section. Such notice shall be communicated contemporaneously with the notification of termination.

(ii) At the time of an event described in subsection (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (4)(a) of this section. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

AMENDATORY SECTION (Amending Order R 92-7, filed 8/19/92, effective 9/19/92)

WAC 284-66-092 Form of "outline of coverage." (1) Cover page.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s)____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs (3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1,500] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

(2) Disclosure page(s):

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your Local Social Security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to WAC 284-66-066(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(3) Charts displaying the feature of each benefit plan offered by the issuer:

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			$[652] (Part A deductible)
First 60 days	All but $[652]	$0	
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	$0	Up to $[81.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs

BLOOD First 3 pints Next $100 of Medicare approved amounts * Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B deductible) $0
CLINICAL LABORATORY SERVICES -- BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First $100 of Medicare approved amounts * Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $100 (Part B deductible) $0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	$0	Up to $[81.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs

BLOOD First 3 pints Next $100 of Medicare approved amounts * Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B deductible) $0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First $100 of Medicare approved amounts * Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B deductible) $0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts *	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts *	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $100 of Medicare approved amounts *	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[652] (Part A	
First 60 days	All but $[652]	deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $100 of Medicare approved amounts * Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	 $0 Generally 80% $0	 $0 Generally 20% $0	 $100 (Part B deductible) $0 All costs
BLOOD First 3 pints Next $100 of Medicare approved amounts * Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B deductible) $0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[652] (Part A	
First 60 days	All but $[652]	deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN E (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICARE CARE BENEFIT - NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

PLAN F OR HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1,500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE, ** YOU PAY

HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[652] (Part A	
First 60 days	All but $[652]	deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F OR HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1,500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE, ** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts *	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts *	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $100 of Medicare approved amounts *	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN F OR HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $100 of Medicare approved amounts * Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	$0 Generally 80% $0	$0 Generally 20% 80%	$100 (Part B deductible) $0 20%
BLOOD First 3 pints Next $100 of Medicare approved amounts * Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B deductible) $0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First $100 of Medicare approved amounts * Remainder of Medicare approved amounts AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan - - - Benefit for each visit - - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - - - Calendar year maximum	100% $0 80% $0 $0 $0	$0 $0 20% Actual charges to $40 a visit Up to the number of Medicare approved visits, not to exceed 7 each week $1,600	$0 $100 (Part B deductible) $0 Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[652] (Part A deductible)	
First 60 days	All but $[652]		$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $100 of Medicare approved amounts * Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	$0 Generally 80% $0	$0 Generally 20% 100%	$100 (Part B deductible) $0 All costs
BLOOD First 3 pints Next $100 of Medicare approved amounts * Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $100 (Part B deductible) $0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First $100 of Medicare approved amounts * Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B deductible) $0

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[652] (Part A	
First 60 days	All but $[652]	deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare	
- - - Additional 365 days	$0	eligible expenses	$0
- - - Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0

BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I (continued)

PART S A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $100 of Medicare approved amounts *	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan		Actual charges to $40 a visit	
- - - Benefit for each visit	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0 $0	$1,600	
- - - Calendar year maximum			

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges *	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J OR HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1,500] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[652] (Part A deductible)	
First 60 days	All but $[652]		$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
- - - Once lifetime reserve days are used:		100% of Medicare eligible expenses	
- - - Additional 365 days	$0		$0***
- - - Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$81.50]/day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN J OR HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1,500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE, ** YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $100 of Medicare approved amounts * Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	 $0 Generally 80% $0	 $100 (Part B deductible) Generally 20% 100%	 $0 $0 $0
BLOOD First 3 pints Next $100 of Medicare approved amounts * Remainder of Medicare approved amounts	$0 $0 80%	All costs $100 (Part B deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES --BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN J OR HIGH DEDUCTIBLE PLAN J (continued)
PARTS A & B

SERVICE	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE, ** YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First $100 of Medicare approved amounts * Remainder of Medicare approved amounts AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan - - - Benefit for each visit - - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - - - Calendar year maximum	100% $0 80% $0 $0 $0	$0 $100 (Part B deductible) 20% Actual charges to $40 a visit Up to the number of Medicare approved visits, not to exceed 7 each week $1,600	$0 $0 $0 Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1,500 DEDUCTIBLE, ** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS -NOT COVERED BY MEDICARE First $250 each calendar year Next $6,000 each calendar year Over $6,000 each calendar year	$0 $0 $0	$0 50% - $3,000 calendar year maximum benefit $0	$250 50% All costs

PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: Fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-110 Buyer's guide. (1) Issuers of disability insurance policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare must provide to all such applicants the pamphlet *"Guide to Health Insurance for People with Medicare,"* a *("Guide")* developed jointly by the National Association of Insurance Commissioners and Health Care Financing Administration, or any reproduction or official revision of that pamphlet. The *Guide* shall be printed in a style and with a type character that is easily read by an average person eligible for Medicare supplement insurance and in no case may the type size be smaller than 12-point type. (Specimen copies may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C.)

(2) Delivery of the *Guide* shall be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement insurance policies or certificates.

(3) Except in the case of a direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

(4) The *Guide* shall be reproduced in a form that is substantially identical in language, format, type size, type proportional spacing, bold character, and line spacing to the *Guide* developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-120 Notice regarding policies which are not Medicare supplement policies. Any disability insurance policy or certificate (other than a Medicare supplement policy or certificate or a policy issued pursuant to a contract under Section 1876 of the Social Security Act (42 U.S.C. Section 1395 et seq.)), disability income protection policy or other policy identified in RCW 48.66.020(1), whether issued on an individual or group basis, which policy purports to provide coverage to residents of this state eligible for Medicare, shall notify policyholders or certificateholders that the policy is not a Medicare supplement insurance policy or certificate. The notice shall be printed or attached to the first page of the outline of coverage or equivalent disclosure form, and shall be delivered to the policyholder or certificateholder. If no outline of coverage is delivered, the notice shall be attached to the first page of the policy or certificate delivered to insureds. Such notice shall be in no less than twelve point, bold type and shall contain the following language: "This (policy, certificate or subscriber contract) is not a Medicare supplement (policy, certificate or subscriber contract). If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company."

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-142 Form of replacement notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company name] Insurance Company. Your new policy will provide thirty days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other disability coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage.

The replacement policy is being purchased for the following reason(s) (check one):

Additional benefits.

No change in benefits, but lower premiums.

Fewer benefits and lower premiums.

Other. (please specify)

1. If you have had your current Medicare supplement policy less than ((~~six~~)) three months, health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker, or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

.....
(Applicant's Signature)
.....
(Date)
*Signature not required for direct response sales.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-170 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates. (1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least ((~~six~~)) three months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.